

**To:** Audiologists, Nursing Homes, Occupational Therapists, Outpatient Hospital Providers, Physical Therapists, Rehabilitation Agencies, Speech and Hearing Clinics, Speech-Language Pathologists, Therapy Groups, HMOs and Other Managed Care Organizations

## Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for physical therapy, occupational therapy, and speech and language pathology services under BadgerCare Plus.

### BadgerCare Plus Overview

In January 2007, Governor Jim Doyle included in his 2007-09 Biennial Budget proposal an innovative state-sponsored health care program to expand coverage to Wisconsin residents and ensure that all children in Wisconsin have access to affordable health care. This new program is called BadgerCare Plus, and it will start on February 1, 2008.

BadgerCare Plus merges family Medicaid, BadgerCare, and Healthy Start into a single program. BadgerCare Plus will expand enrollment to:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

All individuals enrolled in BadgerCare Plus and Wisconsin Medicaid will be referred to as “members.”

BadgerCare Plus is comprised of two benefit plans, the Standard Plan and the Benchmark Plan. The services covered under the BadgerCare Plus Standard Plan are the same as the current Wisconsin Medicaid program; therefore, the term “Standard Plan” will be used in all future *Updates* to describe the shared policy and billing information. The BadgerCare Plus Benchmark Plan is a more limited plan, modeled after commercial insurance.

New services covered under BadgerCare Plus and Wisconsin Medicaid include over-the-counter tobacco cessation products for all members and mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems. Future *Updates* will describe these new benefits in detail.

Refer to the November 2007 *Update* (2007-79), titled “Introduction to BadgerCare Plus — Wisconsin’s New Health Care Program,” for general information on covered and noncovered services, copayments, and enrollment.

### Covered Services

Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services covered under the Standard Plan and the Benchmark Plan are the same as those covered under the current Wisconsin

Medicaid program. Refer to the appropriate publications for covered services, policies, and procedures.

## **Service Limitations for the Benchmark Plan**

The Benchmark Plan covers up to 20 visits in **each** therapy discipline (PT, OT, and SLP) per member per enrollment year.

The Benchmark Plan also covers up to 36 visits per member per enrollment year for cardiac rehabilitation provided by a physical therapist. This service corresponds with *Current Procedural Terminology* procedure codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring [per session]) and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]). The cardiac rehabilitation visits will not be deducted from the 20 PT visits.

A therapy visit is defined as all therapy services delivered on the same date of service (DOS) by the same performing provider.

Therapy visits in any discipline that exceed the Benchmark Plan service limitations are considered noncovered.

## **Enrollment Year Under BadgerCare Plus**

An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12<sup>th</sup> calendar month.

For example, a member completes their BadgerCare Plus application materials by September 25, 2008. During the month of October, the Department of Health and Family Services (DHFS) reviews the application materials and determines that the member is **eligible** for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the

calendar month in which the DHFS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. **Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.**

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHFS re-enrolls the member into the Benchmark Plan.

**If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year does not reset.** For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHFS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. **Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.** If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

For example, assume a member receives 22 PT visits under the Standard Plan during the first six months of a calendar

year (January 1, 2008, through June 30, 2008). Under the Standard Plan, the member is eligible to receive 35 PT visits before prior authorization is required.

Effective the first day of the seventh month of the calendar year (July 1, 2008), the member's coverage changes to the Benchmark Plan. The Benchmark Plan limits coverage to 20 PT visits per enrollment year. Although the member received 22 PT visits during the first six months of the calendar year while covered under the Standard Plan, these services do not count toward the limits under the Benchmark Plan. The member is eligible to receive 20 PT visits under the Benchmark Plan during the course of the Benchmark Plan enrollment year, which is determined as July 1, 2008, through June 30, 2009.

## **Prior Authorization**

### ***Standard Plan***

Prior authorization policy and procedures are the same under the Standard Plan as they are under the current Wisconsin Medicaid program.

### ***Benchmark Plan***

Prior authorization will not be required for any therapy services provided under the Benchmark Plan. Prior authorization requests submitted for Benchmark Plan members will be returned to providers without adjudication.

## **Reimbursement**

Providers will be reimbursed for services provided to members at the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid maximum allowable fee.

The natural environment enhancement payment for Birth-to-3 services will be reimbursed under both the Standard Plan and the Benchmark Plan.

*Note:* Members of the Benchmark Plan may request therapy services from the provider that exceed the service limitation. These services are considered noncovered. Providers may

collect reimbursement for noncovered services from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

## **Copayments**

### ***Standard Plan***

Copayment amounts under the Standard Plan are the same as they are under the current Wisconsin Medicaid program. Refer to previously published service-specific publications for more information on copayment amounts.

Policy regarding members who are subject to copayments and members who are exempt from copayments is different than that of the current Wisconsin Medicaid program.

Providers should note that the following Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs (previously referred to as Medicaid HMOs).
- Members under 18 years of age with incomes above 100 percent of the Federal Poverty Level (FPL).

Providers are prohibited from collecting copayments from the following Standard Plan members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.
- Members under 18 years of age with incomes at or below 100 percent of the FPL.

Under the Standard Plan, providers **cannot** deny services if a member fails to make his or her copayment.

### ***Benchmark Plan***

The copayment amount for PT, OT, and SLP services under the Benchmark Plan is \$15.00 **per therapy visit**. A

therapy visit is defined as all therapy services delivered on the same DOS by the same performing provider. A single \$15.00 copayment applies regardless of the number or type of procedures administered during the visit.

If a member has two therapy visits with two different providers during a single day, the member is subject to two copayments, one for each visit. However, if a member receives multiple therapy services in the same day from one provider, the member is only subject to one copayment.

There are no monthly or annual copayment limits for therapy services.

Benchmark Plan members residing in a nursing home **are subject to copayment** for therapy visits.

The following members are exempt from copayment requirements under the Benchmark Plan:

- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.

No other members are exempt from the copayment requirement under the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to make his or her copayment.

## **Information Regarding BadgerCare Plus HMOs**

BadgerCare Plus HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. For managed care policy, contact the appropriate managed care organization.

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

PHC 1250